

## Upcoming Changes in the 2013 List of Reportable Conditions

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When healthcare providers, laboratories, healthcare facilities, schools, etc., receive and post their copies of the 2013 List of Reportable Conditions, several changes will be obvious, others less so. This *Epi Notes* article reviews the changes, so that your office will be prepared to continue your roles in disease reporting with DHEC.

### 1. Many conditions now have a shortened reporting time:

**\*\*All conditions that were reportable in 7 days are now reportable in 3 days.\*\***

All **influenza deaths** are now reportable in 24 hours, not just flu deaths of children 18 and younger.

### 2. Alphabetical Order:

Reportable Conditions are now listed in alphabetical order, starting with:

- ! Any outbreak or unusual disease**
- ! Any intentional biological, chemical, or radiological event**
- \* Animal (mammal) bites ... through
- \* Yellow Fever (*Flavivirus*) and Yersiniosis (*Yersinia*, not pestis)

This should help providers when evaluating whether a condition needs to be reported. Providers will not have to look in three separate reporting timeframe boxes for influenza, or in two boxes for syphilis.

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## Childcare Exclusion List



## Updates to the School and Childcare Exclusion Lists for the 2012-2013 Academic Year

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The School and Childcare Exclusion Lists were posted in August 2012 for the 2012-2013 academic year.

Unlike previous lists, these no longer have an expiration date. Updates will be made as needed, and revisions shared via the DHEC website, *Epi Notes*, DHEC Health Advisories, school health list serves, DSS Childcare Licensing mailing lists, etc. as needed. Updated sections of the lists are posted below. Please see the full text of the School and Childcare Exclusion Lists for official agency recommendations: <http://www.scdhec.gov/health/disease/exclusion.htm>.

### Conjunctivitis

- ♦ Exclude children in childcare and students in 1st through 5th grades who have purulent conjunctivitis (defined as pink or red conjunctivae with white

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## Upcoming Changes in the 2013 List of Reportable Conditions

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Note that “**Animal (mammal) bite**” is listed separately from, and is reported separately from, “**Rabies Post Exposure Prophylaxis (PEP) (when administered)**.”

Arboviral illnesses, are now listed as separate conditions: **Eastern Equine Encephalitis, La Crosse Encephalitis, St. Louis Encephalitis**, and **West Nile Virus**. These are not all of the Arboviral conditions (see box.) Providers are encouraged to report any other acute cases of arboviral fever/meningo-encephalitis as “unusual diseases.”

### 3. Some conditions have been combined to assure appropriate/complete reporting:

- ♦ While most conditions are listed alphabetically, the rarely reported **viral hemorrhagic fevers (Ebola, Lassa, Marburg viruses)** are clustered together.
- ♦ **All Acute Hepatitis infections (A, B & E)** are reportable in 24 hours.
- ♦ **All Chronic Hepatitis Infections (B, C, and D)** are reportable in 3 days.
- ♦ **All HIV positive tests** (detection and confirmatory results) are reportable.
- ♦ **All HIV CD4** results are reportable.
- ♦ **All lead tests** are reportable, not just tests on children or elevated test results.

### 4. Timing of Reporting is now indicated by Typeface and Symbols

Instead of clustering conditions into three “boxes” according to when they should be reported, reporting times are now indicated by symbols.

An exclamation point (!) and **bold-face font** indicate a condition **Immediately Reportable by Phone**.  
**! Botulism**

An asterisk (\*) indicates a condition Urgently Reportable within 24 hours by phone.

\* Eastern Equine Encephalitis

All other conditions are reportable within 3 days.  
Leprosy (Hansen’s Disease)

### 5. Two big changes in reporting criteria: Rabies PEP and Varicella

**Rabies PEP:** “Rabies Post Exposure Prophylaxis (when recommended)” has been changed to “**Rabies Post Exposure Prophylaxis (PEP) (when administered)**.” Providers should report the date when the first doses of

Rabies PEP (generally vaccine and immune globulin) are administered. Dates of subsequent doses are not required. We found that data on recommended doses of PEP did not correlate with patients’ having received PEP vaccines and RIG.

**Varicella:**  
Varicella cases are once again reportable individually.

For the past several years, varicella has been reportable as deaths, hospitalizations, and in outbreaks of 5 or more cases in 6 weeks. In 2011, SC DHEC received reports of only 13 cases of varicella. Thus far in 2012, SC DHEC has had 11 reported varicella cases. (See chart 3, page 8.) Given what we know about vaccine efficacy, we would expect far higher numbers of both “regular” and breakthrough varicella cases, even in reporting confined to outbreaks. Thus, now all varicella cases will be reportable to SC DHEC within 3 days of diagnosis by a healthcare provider. This includes identification of varicella by a school nurse.

### 6. Two new conditions, five fewer conditions, some verbiage changes:

#### Two New Conditions:

- ♦ **Babesiosis**, a tickborne infection, has been added. It is reportable within 3 days of diagnosis.
- ♦ “**HIV and AIDS clinical diagnosis**” has been “promoted” from the footnotes and added as a separately reportable condition.

#### Five Fewer Conditions:

- ♦ **Enterobacteriaceae, carbapenem-resistant (CRE) (*E. coli* and *Klebsiella pneumoniae*)** reporting has been removed. These data are now reported to the **National Healthcare Safety Network (NHSN)**.

### Changes for 2013

Shortened reporting time for many conditions—3 days  
Alphabetical order  
Some conditions combined  
Timing of reporting indicated by typeface and symbols  
Two big changes in reporting criteria: Rabies PEP and Varicella  
Two conditions added, five conditions removed, some verbiage changes  
Fewer footnotes.

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## Changes in the 2012 List of Reportable Conditions

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- ♦ **Glanders (*Burkholderia mallei*)** has been removed. This condition is no longer nationally reportable.
- ♦ **Melioidosis (*Burkholderia pseudomallei*)** has been removed. This condition is no longer nationally reportable.
- ♦ **Pesticide poisoning** has been removed. These cases should be promptly managed by Poison Control 800-222-1222.
- ♦ ***Staphylococcus aureus*, Methicillin resistant, bloodstream infections (MRSA-BSI)** reporting has been removed. These data are now reported to the **NHSN**.

### Verbiage Changes:

- ♦ HIV HLA-B5701 now reads **HLA-B5701 and co-receptor assay (L)** (and is only reportable by laboratories).
- ♦ "Meningitis, aseptic" has been changed to "**Meningo-encephalitis, aseptic.**"
- ♦ "Rickettsiosis, Spotted fever (e.g., RMSF)" has been changed to "**Rocky Mountain Spotted Fever (Spotted Fever group).**"

### Fewer footnotes:

The number of footnotes has gone from 14 to 8. This should simplify use of the list.

Providers with questions about reporting of specific list items should contact their Regional Public Health Epidemiology Office (via the phone numbers listed on the back of the chart) or the Division of Acute Disease Epidemiology.

### Background on Disease Reporting in SC

South Carolina Law ([44-29-10](#)) and Regulations ([61-20](#)) require reporting of specified contagious and infectious diseases and conditions to the local health department:

"...in the form and manner as prescribed by DHEC in regulations concerning infectious diseases. The reports must be made to the Bureau of Disease Control in the manner required in the regulations. When available, clinical information supporting the diagnoses, including results of specific diagnostic tests, must be included."

In South Carolina, these diseases and conditions are specified in the [List of Reportable Conditions](#), published annually by the DHEC Bureau of Disease Control.

In addition to diseases, the List also specifies that outbreaks of disease, events such as animal (mammal) bites, results of certain tests (e.g., lead, HIV CD4), and findings suggestive of disease (e.g., hemolytic uremic syndrome) must be reported to DHEC.

**Diseases do not have to be confirmed to be reported -- actions to prevent further spread of disease may be necessary while confirmatory tests are pending.**

### A Note on Arboviral Illnesses:

SC DHEC lists several ARthropod BORne viruses (Arboviral) illnesses in the List of Reportable Conditions. These include mosquitoborne conditions:

- ♦ Malaria,
- ♦ Dengue Fever,
- ♦ Yellow Fever,
- ♦ Eastern Equine Encephalitis,
- ♦ La Crosse Encephalitis,
- ♦ St. Louis Encephalitis,
- ♦ West Nile Virus,

and a tickborne viral condition:

- ♦ Babesiosis.

*(Lyme disease and Rocky Mountain Spotted Fever, which are spread by ticks, are not arboviral illnesses.)*

Providers may encounter other domestic arboviral illnesses, such as California Encephalitis, Powassan Encephalitis, or imported conditions such as Chikungunya virus, Eastern equine encephalitis virus, Japanese Encephalitis, Rift Valley Fever, or other tick-transmitted viral hemorrhagic fevers. Suspected cases of these new, emerging or unusual conditions should be reported immediately to DHEC by phone.

## West Nile Virus Activity Increases in US and SC in 2012

Compiled from reports published by DHEC staff or posted to the DHEC website, along with posted CDC data.

### Background

West Nile virus (WNV) was named for the West Nile district of Uganda, where it was first identified in 1937. The virus arrived in the US in 1999, most likely from Israel or elsewhere in the Middle East, where a similar virus circulated among Israeli domestic geese in 1997-1999. WNV was first identified in South Carolina in 2002, and cases have been reported in South Carolina each year since 2002, except for 2011.

Having been established in the US for several years now, West Nile appears as a seasonal epidemic that flares up in the summer and continues into the fall. Nearly all cases come from the bite of an infected mosquito, although, in a very small number of cases, WNV also has been spread through blood transfusions, organ transplants, breastfeeding and even during pregnancy from mother to baby.

Many types of mosquitoes may carry the virus, including the Southern House Mosquito (*Culex quinquefasciatus*). This type of mosquito breeds anywhere foul water stands for more than a week, such as in rain barrels, tubs, catch basins, cesspools, ditches, ground pools, dairy drains, sewage lagoons, and other similar habitats. It bites at night and may enter homes.

Horses and birds are also affected by this disease.

Mosquitoes often become infected when they feed on infected birds that have the virus in their blood. These mosquitoes then infect horses and humans. Unlike human disease, though, around 35% of infected horses will die from West Nile disease.

### WNV Epidemiology since 1999

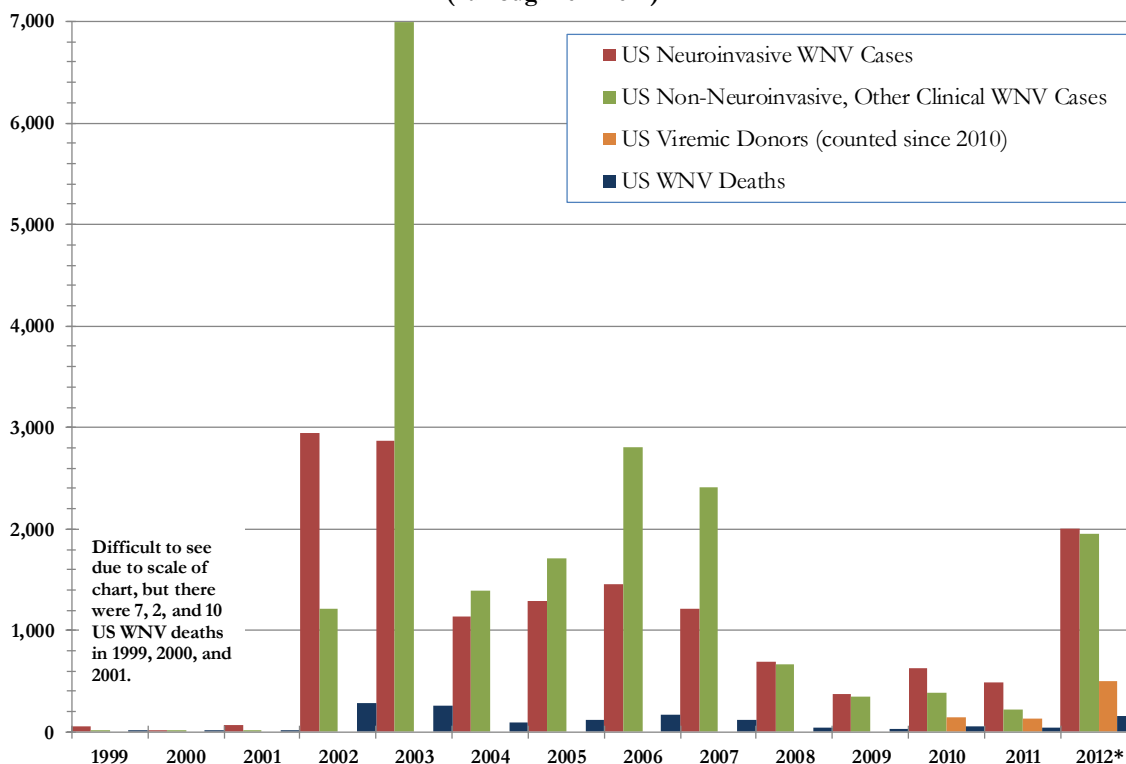
Since most people who acquire West Nile Virus have no symptoms, most cases are never reported. Infection prevalence is estimated through viremia identified by screening of asymptomatic blood donors. Since 2010, viremic blood donors have been included in national and SC statistics for West Nile reporting

**National Data:** Reported West Nile virus cases peaked in the US in 2003, with nearly 10,000 cases of neuroinvasive, non-neuroinvasive, and other clinical symptoms reported to the CDC. In 2002 and 2003, there were 284 and 264 WNV deaths in the US. These numbers have gone down, cyclically, with another short peak in 2006-2007. (See Chart 1, below.)

### Epidemiology in 2012

**National:** As of October 2, 2012, 48 states have reported West Nile virus infections in people, birds, or mosquitoes. 3,969 cases of West Nile virus disease in people, including 163 deaths, have been reported to CDC. Of these, 2,010 (51%) were classified as neuroinvasive disease (such as meningitis or encephalitis) and 1,959 (49%) were classified as non-neuroinvasive disease. The 3,969 cases reported thus far in 2012 is the highest number of West Nile virus disease cases reported to CDC through the first week in October since 2003. The numbers of US

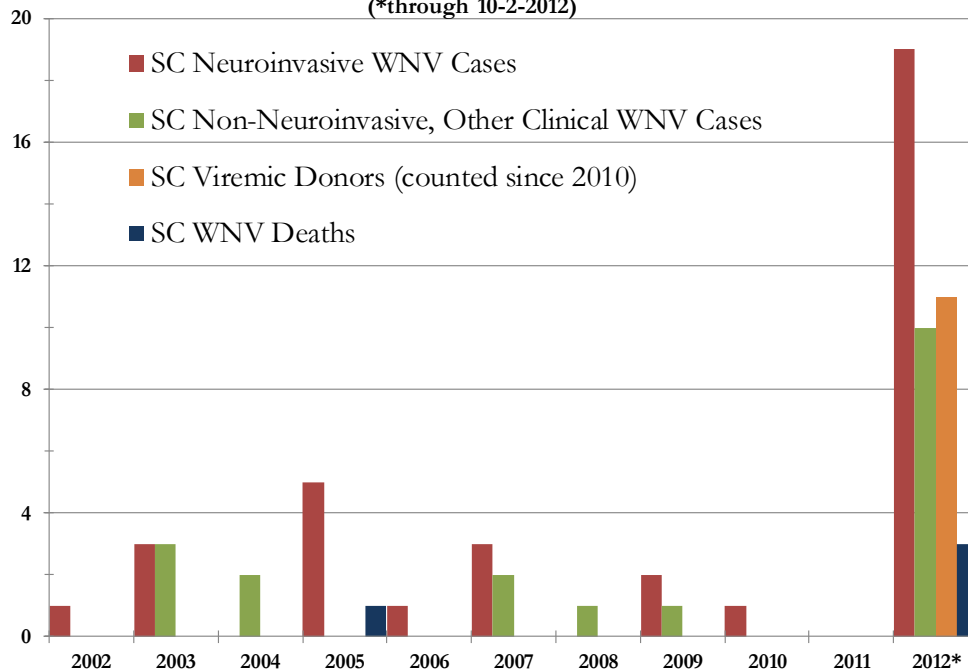
Chart 1. US West Nile Virus Cases, 1999-2012\*, CDC Data  
(\*through 10-2-2012)



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## West Nile Virus Activity Increases in US and SC in 2012

Chart 2. SC West Nile Virus Cases, 1999-2012\*  
(\*through 10-2-2012)



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WNV deaths thus far for 2012 (163) are the highest since 2006 (177). Almost 70 percent of the cases have been reported from eight states (Texas, California, Louisiana, Mississippi, South Dakota, Michigan, Oklahoma, and Illinois) and a third of all cases have been reported from Texas.

**SC Data:** In South Carolina, through October 5, 2012, there were 29 people confirmed ill with West Nile Fever or West Nile Neuroinvasive Disease. Three of these persons died. An additional 11 persons with no symptoms of West Nile infection were identified through screening of donated blood. **South Carolina has experienced more cases of West Nile Disease, in any form, in 2012 than in any previous year.** (See Chart 2, above.)

It will take some time to examine the effects of weather patterns, to review data on susceptible bird populations, etc., to determine why there was a peak this year.

### West Nile Course of Illness

There is no specific treatment for West Nile Virus infection. Fortunately, most infected persons experience no symptoms at all. Their infection might be discovered in routine testing of a donated blood sample.

For those persons who do become ill, symptoms develop 3 to 14 days after the person is infected. People over the

age of 50 years appear to be at greater risk of becoming ill following the bite of an infected mosquito.

Approximately 20% of infected persons develop a flu-like illness called West Nile Fever. This might last for several weeks. Symptoms can include fever, headache, and body aches, and occasionally, a skin rash on the trunk of the body and swollen lymph glands.

About one in 150 people infected with WNV will develop severe illness, referred to as neuroinvasive disease or West Nile Encephalitis. The severe symptoms can include high fever, headache, neck stiffness, stupor, disorientation, coma, tremors, convulsions, muscle weakness, vision loss, numbness, and paralysis. Rash occurs in about 50% of people with West Nile

disease. These symptoms may last several weeks, and neurological effects may be permanent. Anyone experiencing symptoms of rash, fever, and confusion, especially after mosquito bites, should seek medical care promptly.

### WNV Prevention

Prevention measures consist of community-based mosquito control programs that are able to reduce vector populations, personal protection measures to reduce the likelihood of being bitten by infected mosquitoes, and the underlying surveillance programs that characterize spatial/temporal patterns in risk that allow health and vector control agencies to target their interventions and resources. The easiest and best way to avoid WNV is to prevent mosquito bites. DHEC recommends citizens pay attention to the "four Ds" as the most effective ways to prevent WNV: DEET, DRESS, DAWN & DUSK, and DRAIN. (See box, page 9.)

### Reporting West Nile Infections

West Nile Virus, along with other Arboviral conditions, including, but not limited to, Eastern Equine Encephalitis, LaCrosse, and St. Louis Encephalitis (see box, page 3) are reportable to Public Health in South Carolina. Contact your Regional Public Health Department for all suspected and confirmed cases as per the current South Carolina

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## Updates to the School and Childcare Exclusion Lists for the 2012-2013 Academic Year

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or yellow eye discharge, often with matted eyelids after sleep and eye pain or redness of the eyelids or skin surrounding the eye), until evaluated.

- ◆ **No exclusion is required for students in 6th through 12th grades with conjunctivitis unless the student meets other exclusion criteria.** This would include symptoms or other manifestations of possible severe illness – see #1 on either exclusion list, or if there is a recommendation from the health department or the child's healthcare professional.
- ◆ Non-purulent conjunctivitis (defined as pink conjunctivae with a clear, watery eye discharge without fever, eye pain or eyelid redness) does not require exclusion from school or childcare. Per the American Academy of Pediatrics (AAP), "Pinkeye is similar to the common cold, for which exclusion is not recommended. The best method for preventing spread is good hand hygiene."
- ◆ One form of viral conjunctivitis, caused by adenovirus, can cause epidemics. The AAP recommends that "if two or more children in a classroom group care setting develop conjunctivitis in the same period, seek the advice of the program's health consultant."

### Diarrheal Illnesses: Updates for E. coli/STEC

- ◆ Exclude for infection with ***Escherichia coli* O157:H7, or other shiga-toxin producing bacteria (includes STEC)** until diarrhea resolves, AND 2 consecutive **stool specimens** taken at least 24 hours apart test negative for *E. coli* O157:H7 or STEC.
- ◆ Students may be re-admitted for two consecutive negative stool cultures, or for EIA tests that are negative for Shiga-toxin. This exclusion criterion was updated from what appears in the 2012 Red Book (AAP, 2012) due to availability of reliable tests other than culture to determine presence or absence of carriage of STEC.
- ◆ Children with prolonged diarrheal symptoms following completion of treatment for *E. coli* may be re-admitted if cleared by the child's physician.
- ◆ It is recognized that in-school transmission of *E. coli* infection is uncommon among children who do not require diapering, and that there may be an academic burden imposed by lengthy exclusions while awaiting multiple negative culture results. SC DHEC is available for consultations on prolonged exclusions

for sporadic cases of diarrheal illness attributable to *E. coli*.

### Head Lice

Several significant changes were made in school exclusion criteria for head lice, based upon a yearlong project undertaken by SC DHEC and the School Nurse Program Advisory Committee. Updates include an excludable definition of *Pediculus capitis*, treatment recommendations, and re-screening/re-treatment recommendations. A summary of the exclusion and readmission criteria appears below. See the full exclusion lists for exact verbiage for each age group.

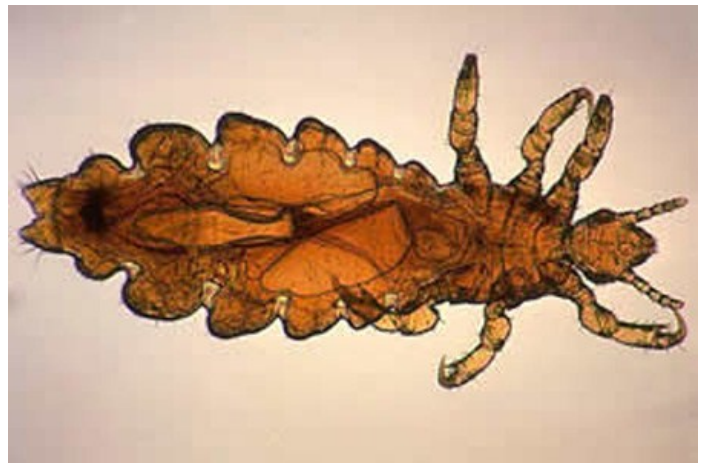


Figure 1: Adult Female Louse. Image from CDC Public Health Image Library. Public Domain.

#### ◆ **Head Lice: When to Exclude**

Exclude students with Head Lice (pediculosis), defined as

- the presence of live, crawling lice visualized on direct inspection of the scalp, and/or
- the presence of nits (eggs) that appear to be ¼ inch or 6 mm from the scalp.

School-age students identified with pediculosis may be allowed to remain in the classroom until the end of the school day, with limitations placed upon activities that cause head-to-head contact.

However, childcare centers may opt to exclude children immediately if close head-to-head contact cannot be avoided in the classroom/center setting.

#### ◆ **Head Lice: Criteria for Return—Screening AND Treatment**

##### 1. Screening:

Excluded students may be readmitted when screening identifies no live, crawling lice on the student's scalp.

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## Updates to the School and Childcare Exclusion Lists for the 2012-2013 Academic Year

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### 2. Treatment:

Excluded students may return with a parent note, after one initial treatment with an over-the-counter or prescription chemical product (shampoo, lotion, oral medication) identified in literature as having pediculicidal activity.

Schools and facilities may opt to allow students to return after one initial treatment with a mechanical lice-removal or pediculicidal method (heat, nit/lice combing).

While no recommendation is made by SC DHEC, school districts and childcare providers may opt to allow students to return after one initial treatment with an herbal or botanical product advertised or identified in literature as having pediculicidal properties. The school/facility may identify acceptable products.

#### ◆ **Head Lice: Re-screening Recommendation**

Students who were identified with pediculosis and excluded should be rescreened at 7-10 days after initial treatments. Rescreened students who are found to have live crawling lice should be re-treated and excluded until screening identifies no live, crawling lice on the student's scalp.

#### ◆ **Head Lice: Other Restrictions**

The AAP recommends that, until the end of the school day, students with head lice avoid any activities that involve the student in head-to-head contact with other students or sharing of any headgear.

Sports or physical education governing bodies may impose additional restrictions on participation.

#### ◆ **Head Lice: "Footnotes" (These are footnotes from the exclusion lists.)**

Students with other evidence of infestation (e.g., nits further than ¼" from the scalp) may be excluded per local policies.

Ideally, pediculosis screening is performed by school health nurses, or by school health aides who have been trained by school nurses.

Local Education Agencies opting for more stringent "No Nit Policies" for school re-admission should clearly explain these policies to families when distributing materials on School Exclusion.

### Contacts in Varicella Outbreaks

- ◆ Unimmunized school children without documentation of immunity or natural disease must be excluded as

indicated below if exposed to an outbreak of Varicella (chicken pox). An outbreak of Varicella is defined as 5 or more cases within 6 weeks in a common setting, such as school, childcare, or other institutional setting.

- ◆ In outbreaks, exclude unimmunized students who with no history of varicella vaccination from day 10 to day 21 after the onset of rash in the last person diagnosed with Varicella in the affected school.
- ◆ Students may return immediately following receipt of varicella vaccine, if vaccine is received within 72 hours of exposure.
- ◆ Pregnant students should not receive Varicella immunization.
- ◆ Mild break-through cases of Varicella (occurring in immunized persons) are generally considered less infectious than cases in unimmunized persons.
- ◆ Consult with SC DHEC as needed for exclusion guidance in on-going outbreaks of Varicella or if/when exclusion may be extended over than one incubation period (i.e., over 21 days).

### Exclusion Not Required (Updates/Additions)

- ◆ Chronic Hepatitis B infection
- ◆ Cough not associated with an infectious disease or a fever
- ◆ Fever, without any other signs of severe illness, if child can participate comfortably in school/program activities.
- ◆ HIV infection

Most of these were addressed elsewhere in notes for other conditions on the list. They are now explicit additions to the Exclusion Lists as conditions that do not require exclusion.

### Print and Web Versions

DHEC has posted full versions of the Exclusion Lists (for schools and healthcare providers) and Parent Versions (printable brochures or text accessible from any device that can access the web).

Type Exclusion into the search box at [www.scdhec.gov](http://www.scdhec.gov) or bookmark [www.scdhec.gov/health/disease/exclusion.htm](http://www.scdhec.gov/health/disease/exclusion.htm)

### References:

- American Academy of Pediatrics. (2009). *Managing Infectious Diseases in Child Care and Schools: A Quick Reference Guide* (2nd ed.). (S. S. Aronson, & T. R. Shope, Eds.) Elk Grove Village, IL: American Academy of Pediatrics.
- American Academy of Pediatrics. (2012). *Red Book: 2012 Report of the Committee on Infectious Diseases* (29th ed.). (L. K. Pickering, C. J. Baker, D. W. Kimberlin, & S. S. Long, Eds.) Elk Grove Village, IL: American Academy of Pediatrics.





## Outbreaks by the Numbers

As of October 12, DHEC's 8 Regional Outbreak Response Teams and the Division of Acute Disease Epidemiology have investigated 137 reports of outbreaks of disease or single cases of illnesses of high public health significance, affecting over 2800 people. Data are preliminary, but trends so far show these as the top conditions, by numbers of outbreaks investigated:

- ♦ Norovirus, type GII,
- ♦ Salmonellosis,
- ♦ Seasonal influenza,
- ♦ Scabies (in long-term care facilities),
- ♦ Hand, foot, and mouth disease (in childcare facilities),
- ♦ Pertussis,
- ♦ Unknown rashes, and
- ♦ Single cases of rare conditions that are investigated as outbreaks.

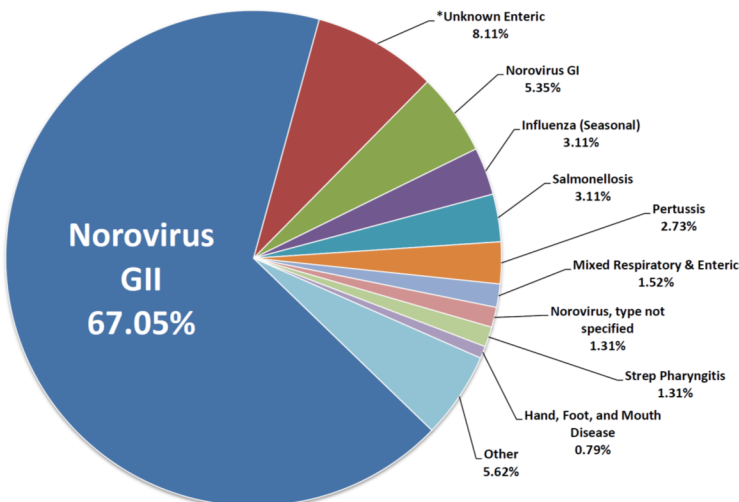


Chart 5. Communicable Disease Outbreaks Investigated by SC DHEC in 2012, through 10-12-2012, by Numbers of Persons Affected.

## West Nile Virus Activity Increases in US and SC in 2012

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List of Reportable Conditions (available at: <http://www.scdhec.gov/administration/library/CR-009025.pdf>)

For more information about West Nile Virus, please visit the following websites:

- **SC DHEC:** [www.scdhec.gov/environment/envhealth/pests/mosquitoes-wnv.htm](http://www.scdhec.gov/environment/envhealth/pests/mosquitoes-wnv.htm), or enter West Nile into the search box at [www.scdhec.gov](http://www.scdhec.gov).
- **Centers for Disease Control and Prevention:** [www.cdc.gov/ncidod/dvbid/westnile/index.htm](http://www.cdc.gov/ncidod/dvbid/westnile/index.htm).

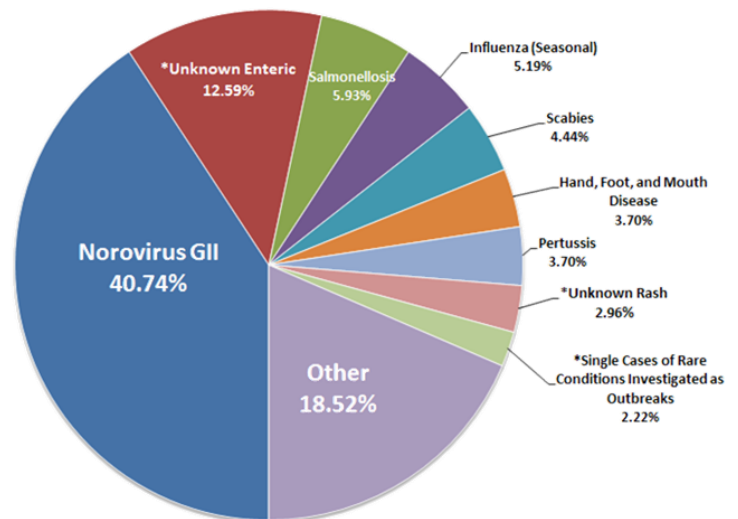


Chart 4. Communicable Disease Outbreaks Investigated by SC DHEC in 2012, through 10-12-2012, by Agent Identified.

The numbers vary somewhat when viewed by number of persons affected, but it remains obvious that enteric illnesses constitute both a large proportion of the number of outbreaks reported to and investigated by SC DHEC, as well as a significant burden upon the health of South Carolinians.

## Preventing Mosquito Bites: The 4 D's

**DEET** – Apply insect repellent containing DEET, picaridin, oil of lemon, eucalyptus, or IR 3535 according to label instructions. Repellents help keep mosquitoes from biting. DEET can be used safely on infants and children 2 months of age and older.

**DRESS** – Wear clothing that reduces the risk of skin exposure.

**DAWN AND DUSK** – Exposure to mosquitoes is most common during the early morning and evening, so it is important to wear repellent at that time. Make sure that your doors and windows have tight-fitting screens to keep out mosquitoes.

**DRAIN** – Mosquitoes lay their eggs on standing water. Eliminate all sources of standing water on your property, including flowerpots, old car tires, rain gutters, and pet bowls. If you have a pond, use mosquito fish (available from your local mosquito and vector control agency) or commercially available products to eliminate mosquito larvae.

## Summary of Conditions reported to SC DHEC January 1 through September 15, 2012

Compiled by Claire Youngblood, MA, Data Manager  
Division of Acute Disease Epidemiology

Condition	Confirmed#	Probable
Animal Bite - Bat (PEP Recommended) ©	104	
Animal Bite - Cat (PEP Recommended) ©	50	
Animal Bite - Dog (PEP Recommended) ©	73	
Animal Bite - Fox (PEP Recommended) ©	10	
Animal Bite - Other (PEP Recommended) ©	15	
Animal Bite - Raccoon (PEP Recommended) ©	21	
Animal Bite - Wild (PEP Recommended) ©	5	
Aseptic meningitis	141	0
Botulism, other (includes wound)	*	0
Campylobacteriosis	319	8
Cryptosporidiosis	17	21
Dengue Fever	*	*
Ehrlichiosis, chaffeensis	*	0
Encephalitis, West Nile	4	4
Encephalitis/meningitis, California serogroup viral	*	0
Giardiasis	90	0
Group A Streptococcus, invasive	58	0
Group B Streptococcus, invasive	35	0
Haemophilus influenzae, invasive	48	0
Hemolytic uremic syndrome, post-diarrheal	*	*
Hepatitis A, acute	5	0
Hepatitis B virus infection, Chronic	27	318
Hepatitis B, acute	34	*
Hepatitis C Virus Infection, past or present	2,834	6
Hepatitis C, acute	*	0
Hepatitis Delta co- or super-infection, acute	*	0
Influenza, human isolates	98	0
Legionellosis	20	0
Listeriosis	7	0
Lyme disease	23	5

## Summary of Conditions reported to SC DHEC January 1 through September 15, 2012

Condition	Confirmed	Probable
Malaria	8	0
Mumps	0	*
Neisseria meningitidis, invasive (Meningococcal disease)	*	0
Pertussis	126	58
Q fever	0	*
Salmonellosis	1,036	*
Shiga toxin-producing <i>Escherichia coli</i> (STEC)	14	6
Shigellosis	19	*
Spotted Fever Rickettsiosis (Rocky Mountain Spotted Fever)	10	41
Strep pneumoniae, invasive	284	0
Streptococcal toxic-shock syndrome	4	0
Streptococcus pneumoniae, invasive disease (IPD)	*	0
Tetanus	0	*
Tuberculosis	79	0
Typhoid fever ( <i>Salmonella typhi</i> )	*	0
Varicella (Chickenpox)	8	*
Vibrio parahaemolyticus	*	0
Vibrio spp., non-toxigenic, other or unspecified	7	0
Vibrio vulnificus infection	*	0
West Nile Fever	16	*
Yersiniosis	*	0

¶ To save space, reportable conditions with no cases reported are not included in this list.

‡ Not all conditions on this list have an "official" probable or confirmed status defined. Case status indicated on these pages is based upon what is reported in the Carolina's Health Electronic Surveillance System.

\* To avoid identifying specific patients, cell values >0, but less than 4 are suppressed.

© Animal Bites, PEP (Post-exposure prophylaxis) Recommended, are submitted as morbidity reports. These do not have a "confirmed" or "probable" case status defined. All animal bites for which PEP was recommended = 284 through September 15. In addition to those above, this number also included bites from farm animals, ferrets, and skunks.

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Data are preliminary, and include only those reports for which a final cases status has been assigned. Conditions with no reported cases may have no reports, or may be the subject of on-going investigations. Most recent complete full-year data are available from the SC DHEC Annual Report on Reportable Conditions: [http://www.scdhec.gov/health/disease/docs/Annual\\_Report\\_on\\_Reportable\\_Conditions.pdf](http://www.scdhec.gov/health/disease/docs/Annual_Report_on_Reportable_Conditions.pdf). Questions may be directed to the Surveillance Section of the SC DHEC Bureau of Disease Control's Division of Acute Disease Epidemiology.



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**DISEASE REPORTING**

For immediately and urgently reportable conditions, call your local county health department. After hours, weekends or holidays, call 1-888-847-0902. Routine reports may be phoned in to your local health department or mailed on a completed DHEC DISEASE REPORTING CARD (DHEC 1129.) Local county health department numbers are listed on the Official List of Reportable Conditions.

For a copy of the current Official List of Reportable Conditions, call 803-898-0861 or visit [www.scdhec.gov/health/disease/reportables.htm](http://www.scdhec.gov/health/disease/reportables.htm).

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# Flu Watch

Flu season has arrived. Be sure to check DHEC's weekly Flu Watch for updates on influenza activity in South Carolina.

- ◆ Click the graphic to the left,
- ◆ Click "Flu in SC" from DHEC's home page, or
- ◆ Bookmark DHEC's 2012-2013 SC Flu Activity and Surveillance Page in your browser:  
[www.scdhec.gov/flu/flu-activity-surveillance.htm](http://www.scdhec.gov/flu/flu-activity-surveillance.htm)

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[www.scdhec.gov/health/disease/](http://www.scdhec.gov/health/disease/)

If you are a health professional interested in receiving health notifications from the **South Carolina Health Alert Network**, please contact Shana Dorsey, HAN Coordinator at 803-898-0431 or email [DADE-OC@dhec.sc.gov](mailto:DADE-OC@dhec.sc.gov).